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David R. Williams

University of Michigan, Institute for Social Research

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RACE, HEALTH, AND HEALTH CARE

DAVID R. WILLIAMS*

I. INTRODUCTION

This Article provides an overview of racial and ethnic disparities in health status in the United States and describes the complex ways in which race, ethnicity and socioeconomic status (SES) combine to affect the distribution of disease. It outlines the multiple factors that contribute to racial differences in health status at “equivalent” levels of SES and reviews the evidence of inequalities in health care access and quality and examines their potential contribution to disparities in health status.

II. RACE, ETHNICITY AND HEALTH STATUS

In 1999, the Kaiser Family Foundation conducted a national survey on public awareness of the extent of racial disparities in health care in the United States.¹ The study found that most Americans were unaware that racial disparities in health existed.² The first row of Table 1 shows relatively low levels of public awareness that African-Americans (or Blacks) have higher infant mortality rates than whites. Official health statistics reveal that the infant mortality rate in 1999 was almost 2.5 times higher for blacks compared to whites.³ Moreover, these differences in infant death rates have existed for a long time. In 1950, a Black infant was about 1.6 times more likely to die before his or her first birthday than a white infant.⁴ Infant death rates in 1999 were approximately three times lower for blacks and four times lower for

* Harold Cruse Collegiate Professor of Sociology, Department of Sociology; Professor of Epidemiology, School of Public Health; and Senior Research Scientist, Survey Research Center, Institute for Social Research, University of Michigan.

1. THE HENRY J. KAISER FAMILY FOUNDATION, RACE, ETHNICITY & MEDICAL CARE: A SURVEY OF PUBLIC PERCEPTIONS AND EXPERIENCES (1999) [hereinafter THE HENRY J. KAISER FAMILY FOUNDATION].

2. *Id.* at 7.

3. NAT'L CTR. FOR HEALTH STATISTICS, U.S. DEP'T OF HEALTH AND HUMAN SERVS., HEALTH, UNITED STATES, 2002, WITH CHARTBOOK ON TRENDS IN THE HEALTH OF AMERICANS 45, 65 (2002), available at <http://www.cdc.gov/nchs/hus.htm> [hereinafter NAT'L CTR. FOR HEALTH STATISTICS].

4. *Id.* at 109 (Table 23).

whites than in 1950, but the relative gap between them has widened.⁵ In light of this persisting disparity, it is striking to see that in 1999, 55% of whites, 58% of African-Americans, and 65% of Hispanics (or Latinos) surveyed are unaware that Black babies are more likely to die before their first birthday than white infants.

Table 1⁶

Public Perceptions of Racial Disparities

Percent agreeing that the average black is worse than the average white in terms of . . .

Issue	White	Black	Latino
1. Infant Mortality	45	42	35
2. Life Expectancy	43	46	32
3. Education	36	57	33
4. Income	53	65	45
5. Housing	49	64	43
6. Getting Medical Care	36	53	37

Life expectancy is another widely used overall indicator of health status. In 1900, whites had a life expectancy at birth of 48 years compared to 33 years for non-whites (a category that consisted mainly of Blacks).⁷ Life expectancy has dramatically improved over time for both racial groups, but the racial gap in life expectancy persists. In 1999, white males at birth had a 74.6-year life expectancy and could expect to live almost seven years longer than African-

5. *Id.* at 109-10.

6. THE HENRY J. KAISER FAMILY FOUNDATION, *supra* note 1, at 8-9.

7. NAT'L CTR. FOR HEALTH STATISTICS, *supra* note 3, at 116 (Table 28).

American males, whose life expectancy was 67.8 years.⁸ Similarly, white females on average could be expected at birth to live five years longer than black females (79.9 vs. 74.7 years).⁹ However, according to Table 1, fifty-seven percent of whites, fifty-four percent of African-Americans, and sixty-eight percent of Hispanics were unaware that the average African-American has a shorter life expectancy than the average white person.

Racial and ethnic disparities are pervasive across a broad range of health outcomes and for multiple populations in the United States. Table 2 presents overall death rates for whites and the minority-to-white ratios for each of the major racial and ethnic populations in the United States. The major minority populations can be broadly divided into those groups that have had a long-term history in the United States characterized by marked geographic and socioeconomic isolation and discrimination (Blacks and American Indians) and those that are heavily made up of more recent immigrants to the United States (Asian-Americans and Hispanics).

The pattern of racial and ethnic disparities in health differs for these two broad groups. For African-Americans and American Indians, racial disparities in health are large during early childhood, somewhat reduced during the rest of childhood and early adolescence, but they re-emerge clearly in late adolescence and persist through the retirement years, eventually falling beneath the white death rate for American Indians after the age of seventy-five and for African-Americans after age eighty-five. The racial disparities in health at older ages must be understood in light of the powerful selection effects that determine survival into late life in the first place. Specifically, large racial disparities in health at younger ages for both Native Americans and African-Americans contribute to the higher rates of illness and death that restrict the number of persons who actually survive long enough to reach old age.¹⁰

8. *Id.*

9. *Id.*

10. David R. Williams & Colwick M. Wilson, *Race, Ethnicity, and Aging*, in HANDBOOK OF AGING AND THE SOCIAL SCIENCES 160 (Robert H. Binstock & Linda K. George eds., 5th ed. 2001).

Table 2¹¹

Age-Specific Death Rates for Whites
and Minority/White Rates for 1999–2000¹²

Age	White (W) Rate	Black/W Ratio	AmInd/W Ratio	API/W Ratio	Hispanic/W Ratio
1–4	0.3	2.0	2.0	0.7	1.0
5–14	0.2	1.5	1.0	0.5	1.0
15–24	0.7	1.9	1.7	0.6	1.3
25–34	0.9	2.2	1.8	0.6	1.1
35–44	1.8	2.1	1.7	0.5	0.9
45–54	3.9	2.1	1.3	0.5	0.8
55–64	9.6	1.8	1.2	0.6	0.8
65–74	24.1	1.4	1.0	0.6	0.7
75–84	57.3	1.2	0.7	0.6	0.6
85+	158.3	0.9	0.4	0.6	0.6

Higher illness rates across multiple health outcomes underlie the elevated mortality for Blacks and American Indians. African-Americans have higher death rates than whites for most of the fifteen leading causes of death.¹³ American Indians have higher death rates for diabetes, liver cirrhosis, accidents, and suicide, but lower rates than whites for heart disease, cancer, and stroke.¹⁴

Table 2 reveals that Asian and Pacific Islanders have lower death rates than whites at all ages across the life course. Hispanics have death rates that

11. NAT'L CTR. FOR HEALTH STATISTICS, U.S. DEP'T OF HEALTH AND HUMAN SERVS., MORTALITY TABLES, at <http://www.cdc.gov/nchs/datawh/statab/unpubd/mortabs.htm> (last reviewed Nov. 7, 2003) [hereinafter MORTALITY TABLES]. In the table, API represents Asian or Pacific Islanders.

12. Rates were calculated per 100,000 population. *Id.* at 18.

13. *Id.* at 18–22, 34–39. *See also* NAT'L CTR. FOR HEALTH STATISTICS, *supra* note 3, at 127 (Table 32).

14. *See* MORTALITY TABLES, *supra* note 11, at 51–55; NAT'L CTR. FOR HEALTH STATISTICS, *supra* note 3, at 127–28 (Table 32).

are equivalent to those of whites in early life, become slightly larger in early adulthood, but then remain lower than those of whites throughout the rest of the life span. Both Hispanics and Asians have markedly lower death rates than whites for the three leading causes of death—heart disease, cancer, and stroke—that are responsible for some sixty percent of all deaths in the United States.¹⁵ A pattern of equivalent or lower death rates than whites exists for Asians for each of the fifteen leading causes of death in the United States.¹⁶ In contrast, Hispanics have higher death rates than whites for diabetes, liver cirrhosis, and homicide.¹⁷

Relatively high proportions of both the Asian and Hispanic population are foreign-born, and the health effects of migration play an important role in these overall health patterns. Immigrants of all major racial and ethnic populations enjoy lower rates of infant mortality and adult mortality than their native-born counterparts.¹⁸ Moreover, research shows that with length of stay in the United States, the overall health advantage of Hispanics disappears, and the health profile of Hispanics converges to that of the white population.¹⁹ This research documents that poor health practices among Hispanics increase with the length of stay in the United States. An earlier body of research on Japanese-Americans found a similar pattern of the increased risk for cardiovascular disease correlated with acculturation.²⁰

It is likely, though, that the trajectory for these two groups in terms of both socioeconomic status and health may be very different. Immigrants from Asian countries and Hispanic societies differ markedly in terms of their level of SES. For example, sixty-five percent of immigrants from India, forty-three percent from the Philippines, and thirty-five percent from Japan are college graduates, compared with four percent of those from Mexico, five percent from El Salvador, and six percent of those from Guatemala.²¹ Both groups continue

15. NAT'L CTR. FOR HEALTH STATISTICS, *supra* note 3, at 127-30 (Table 32).

16. *Id.*

17. *Id.*

18. Robert A. Hummer et al., *Race/Ethnicity, Nativity, and U.S. Adult Mortality*, SOC. SCI. Q., March 1999, at 136-37, 147, 149-51; Gopal K. Singh & Stella M. Yu, *Adverse Pregnancy Outcomes: Differences Between US- and Foreign-Born Women in Major US Racial and Ethnic Groups*, 86 AM. J. PUB. HEALTH 837, 842 (1996).

19. William A. Vega & Hortensia Amaro, *Latino Outlook: Good Health, Uncertain Prognosis*, 15 ANN. REV. PUB. HEALTH, 39, 57-59 (1994); *see also* Benjamin S. Bradshaw & W. Parker Frisbie, *Mortality of Mexican Americans and Mexican Immigrants: Comparisons with Mexico*, in DEMOGRAPHIC DYNAMICS OF THE U.S.-MEXICO BORDER 125 (John R. Weeks & Roberto Ham-Chande eds., 1992).

20. Michael G. Marmot & S. Leonard Syme, *Acculturation and Coronary Heart Disease in Japanese-Americans*, 104 AM. J. EPIDEMIOLOGY 225, 245 (1976).

21. Rubén G. Rumbaut, *Origins and Destinies: Immigration, Race, and Ethnicity in Contemporary America*, in ORIGINS AND DESTINIES: IMMIGRATION, RACE, AND ETHNICITY IN AMERICA 21, 36-37 (Silvia Pedraza & Rubén G. Rumbaut eds., 1996).

to experience discrimination,²² but compared to Asians, Hispanics experience higher levels of segregation,²³ are viewed more negatively by whites,²⁴ and face greater challenges with educational and occupational mobility.²⁵ At the same time, each group contains considerable heterogeneity. Some Asian immigrant groups such as the Hmong, Laotians, and Cambodians have low levels of educational attainment. Also, for example, one Hispanic group, Cuban immigrants, is three times as likely as their Mexican counterparts to be college graduates.²⁶

Several factors should be considered to put this data into perspective. First, American Indians who live on or near reservations (sixty percent of the total population) have poorer health outcomes than the overall national profile of their group.²⁷ Second, data quality problems affect the accuracy of the national mortality data. The misreporting of racial and ethnic status on death certificates (many are misclassified as non-Hispanic white) understates overall mortality rates for American Indians,²⁸ Asian and Pacific Islanders,²⁹ and Hispanics.³⁰ Third, all of the major groups are characterized by considerable heterogeneity that predicts considerable variation in both SES and health status.³¹ Finally, the grouping of Pacific Islanders with the Asian population in most U.S. data obscures some of the serious socioeconomic and health challenges faced by this group. The current federal guidelines for measuring race and ethnicity have a new category for Native Hawaiians and other Pacific

22. See David R. Williams, *Race, Stress and Mental Health*, in MINORITY HEALTH IN AMERICA: FINDINGS AND POLICY IMPLICATIONS FROM THE COMMONWEALTH FUND MINORITY HEALTH SURVEY 209 (Carol J. R. Hogue et al. eds., 2000) [hereinafter MINORITY HEALTH IN AMERICA].

23. Douglas S. Massey, *Residential Segregation and Neighborhood Conditions in U.S. Metropolitan Areas*, in COMM'N ON BEHAVIORAL AND SOCIAL SCIENCES AND EDUCATION, NAT'L RESEARCH COUNCIL, 1 AMERICA BECOMING: RACIAL TRENDS AND THEIR CONSEQUENCES 391 (Neil J. Smelser et al. eds, 2001) [hereinafter 1 AMERICA BECOMING].

24. See generally JAMES A. DAVIS ET AL., GENERAL SOCIAL SURVEYS, 1972-1998: CUMULATIVE CODEBOOK (1999).

25. Albert M. Camarillo & Frank Bonilla, *Hispanics in a Multicultural Society: A New American Dilemma?*, in 1 AMERICA BECOMING, *supra* note 23, at 103.

26. Rumbaut, *supra* note 21, at 36-37, 39.

27. See generally INDIAN HEALTH SERV., U.S. DEP'T OF HEALTH & HUMAN SERVS., REGIONAL DIFFERENCES IN INDIAN HEALTH (1997).

28. Robert A. Hahn, *The State of Federal Health Statistics on Racial and Ethnic Groups*, 267 JAMA 268, 270 (1992).

29. *Id.*

30. See Paul D. Sorlie et al., *Mortality by Hispanic Status in the United States*, 270 JAMA 2464 (1993).

31. David R. Williams, *Racial Variations in Adult Health Status: Patterns, Paradoxes, and Prospects*, in 2 AMERICA BECOMING: RACIAL TRENDS AND THEIR CONSEQUENCES 371 (Neil J. Smelser et al. eds, 2001) [hereinafter 2 AMERICA BECOMING].

Islanders.³² The utilization of this new category can highlight more clearly some of the serious challenges faced by this group—a group whose overall health profile is more similar to that of American Indians and African-Americans than it is to that of Hispanics or Asian-Americans.³³

III. UNDERSTANDING RACIAL DISPARITIES IN HEALTH

Early explanations of racial disparities in health in the United States focused on the biological differences between Blacks and whites and saw any racial difference in health as a consequence of racial variations in biological characteristics.³⁴ Scientific data clearly indicate that although there is genetic variation within human populations, our racial categories do not capture them well. Racial categories were developed in the absence of genetic evidence and before modern theories of genetics.³⁵ Being a member of any of the socially defined racial groups is not a reliable or unambiguous indicator of the possession of particular genetic characteristics. There are variations in human population groups in the frequency of particular genetic characteristics, some of which may be health-related,³⁶ however, most genetic variation exists within the major racial categories, with only a small percentage of variation that can be assigned to differences between groups.³⁷

The American Association of Physical Anthropologists recently concluded that “[p]ure races, in the sense of genetically homogenous populations, do not exist in the human species today, nor is there any evidence that they have ever existed in the past.”³⁸ In light of such evidence, some have suggested that race should no longer be studied in relationship to health.³⁹ Recently, an American

32. Revisions to the Standards for the Classification of Federal Data on Race and Ethnicity, 62 Fed. Reg. 58,782, 58,786 (Oct. 30, 1997).

33. Y. Cho & R. A. Hummer, *Disability Status Differentials Across Fifteen Asian and Pacific Islander Groups and the Effect of Nativity and Duration of Residence in the U.S.*, 48 SOCIAL BIOLOGY 171 (2001); W. Parker Frisbie et al., *Immigration and the Health of Asian and Pacific Islander Adults in the United States*, 153 AMER. J. OF EPIDEMIOLOGY 372-80 (2001).

34. Nancy Krieger, *Shades of Difference: Theoretical Underpinnings of the Medical Controversy on Black/White Differences in the United States, 1830–1870*, 17 INT’L J. HEALTH SERVS. 259, 262-63 (1987).

35. C. Loring Brace, *The Roots of the Race Concept in American Physical Anthropology*, in A HISTORY OF AMERICAN PHYSICAL ANTHROPOLOGY 1930–1980, at 11 (Frank Spencer ed., 1982); THE CONCEPT OF RACE (Ashley Montagu ed., 1964).

36. Neil Risch et al., *Categorization of Humans in Biomedical Research: Genes, Race, and Disease*, GENOME BIOLOGY, JULY 2002.

37. See R. C. Lewontin, *The Apportionment of Human Diversity*, in EVOLUTIONARY BIOLOGY 381 (Theodosius Dobzhansky et al. eds., 1972).

38. AAPA *Statement on Biological Aspects of Race*, 101 AM. J. PHYS. ANTHRO. 569, 569 (1996).

39. Christopher Bagley, *A Plea for Ignoring Race and Including Insured Status in American Research Reports on Social Science and Medicine*, 40 SOC. SCI. & MED. 1017 (1995); Mindy

Sociological Association (ASA) statement on race argued that although race may not be a meaningful concept in terms of identifying biological characteristics, it is socially consequential in a broad range of domains, including health, and it is thus critical to continue to assess race and its consequences, both to inform policymaking and to achieve greater justice in society.⁴⁰ At the same time, there is growing recognition among health researchers that understanding the determinants of health will require comprehensive characterization of genetic and biological characteristics as well as environmental factors and the complex interactions among them.⁴¹

In the United States, race is consequential in determining residential patterns, as well as educational and employment opportunities.⁴² Thus, race is a strong predictor of variations in socioeconomic circumstances. The data in Table 1 indicate that more Americans are aware of racial differences in SES than in health.⁴³ The majority of African-Americans are aware of racial differences in education, income, and housing, but a clear majority of whites perceive racial inequality only in the area of income.⁴⁴ National data, however, reveal that compared to whites, African-Americans, Latinos, and American Indians have lower levels of not only income, but also education, occupational status, and wealth, and higher rates of poverty and unemployment.⁴⁵ These socioeconomic indicators are some of the strongest known determinants of variations in health,⁴⁶ and SES accounts for a large part of the poorer health status of historically disadvantaged racial groups.⁴⁷

Thompson Fullilove, Comment, *Abandoning "Race" as a Variable in Public Health Research—An Idea Whose Time has Come*, 88 AM. J. PUB. HEALTH 1297 (1998).

40. AM. SOC. ASS'N, THE IMPORTANCE OF COLLECTING DATA AND DOING SOCIAL SCIENTIFIC RESEARCH ON RACE (2003) [hereinafter AM. SOC. ASS'N].

41. See Bruce S. McEwen, *Protective and Damaging Effects of Stress Mediators*, 338 NEW ENG. J. MED. 171 (1998); see also COMM. ON FUTURE DIRECTIONS FOR BEHAVIORAL AND SOCIAL SCIENCES RESEARCH AT THE NAT'L INSTS. OF HEALTH, NAT'L RESEARCH COUNCIL, NEW HORIZONS IN HEALTH: AN INTEGRATIVE APPROACH (Burton H. Singer & Carol D. Ryff eds., 2001).

42. AM. SOC. ASS'N, *supra* note 40.

43. See *supra* note 6 and accompanying table.

44. *Id.*

45. U.S. CENSUS BUREAU, STATISTICAL ABSTRACT OF THE UNITED STATES: 2001, at 40-43 (2001) [hereinafter U.S. CENSUS BUREAU].

46. Nancy E. Adler et al., *Socioeconomic Inequalities in Health: No Easy Solution*, 269 JAMA 3140, 3140 (1993).

47. David R. Williams & Chiquita Collins, *US Socioeconomic and Racial Differences in Health: Patterns and Explanations*, 21 ANN. REV. SOCIOLOGY 349, 363 (John Hagan & Karen S. Cook eds., 1995).

IV. RACE, SES AND HEALTH

Table 3 provides national data on the complex relationship between race, SES, and health. The first row shows that at age twenty-five, white men and women have a life expectancy that exceeds that of their Black counterparts by more than four years. However, for both men and women, Blacks and whites, as education increases, life expectancy also increases. African-American men who have completed thirteen or more years of education live 6.7 years longer than those who have not graduated from high school. The comparable number for whites is 5.4 years. Thus, the differences within each racial group by even this crude measure of educational variation are larger than the Black–white difference. A similar pattern is evident for women, although the SES differences are smaller, especially among white women. At age twenty-five, Black women in the highest educational category have a life expectancy that is 5.9 years longer than those in the lowest educational group. Among white women, the educational difference is only 2.8 years between women in the highest educational category and the lowest. Other data reveal that because white women are much more likely to be married than Black women, the racial differences in education among women dramatically understate racial differences in household income.⁴⁸

Table 3⁴⁹

Life Expectancy at Age 25

Education	Males			Females		
	White	Black	Difference	White	Black	Difference
All	50.1	45.7	4.4	56.7	52.4	4.3
<12 yrs.	47.2	43.5	3.7	55.1	50.2	4.9
12 yrs.	50.2	46.5	3.7	57	53.6	3
13+ yrs.	52.6	50.2	2.4	57.9	56.1	1.8
SES Difference	5.4		6.7		2.8	5.9

48. David R. Williams, *Racial/Ethnic Variations in Women's Health: The Social Embeddedness of Health*, 92 AM. J. PUB. HEALTH 588, 592 (2002).

49. Charles C. Lin et al., *A Further Study of Life Expectancy by Socioeconomic Factors in the National Longitudinal Mortality Study*, 13 ETHNICITY & DISEASE 240, 243 (2003).

Table 3 also indicates that although racial differences in health status usually decrease when Blacks and whites are compared at similar levels of SES, there remains an independent effect of race on health status. This striking persistence of an effect of race independent of SES is evident in other health data.⁵⁰ For both men and women, African-Americans have lower levels of life expectancy than their white counterparts at every level of education. For example, white men who have not completed high school have a life expectancy that is 3.7 years longer than similarly educated Black men. Among women, the racial difference in life expectancy at the lowest educational level is almost five years. Among the most educated, the racial difference is 2.4 years for men and 1.8 years for women.

Several factors, singly and in combination, may contribute to this persistence of an effect of race. First, all of the routinely used indicators of SES are not equivalent across racial and ethnic categories.⁵¹ There are large racial differences in the quality of elementary and high school education, so that Black high school graduates bring fewer basic skills to the labor market than their white counterparts.⁵² In addition, at every level of education whites have a higher median income than Blacks and Hispanics.⁵³ These disparities are larger among males than among females.⁵⁴ Moreover, even after taking differences in test scores into account, African-Americans still earn less than their white peers.⁵⁵

Thus, the equalization of levels of education would still leave a large racial gap in earned income. "Middle class blacks are also more likely than their white peers to be recent and tenuous in that class status. College-educated blacks, for example, are . . . more likely than their white peers to experience unemployment."⁵⁶ As research has indicated:

50. See, e.g., NAT'L CTR. FOR HEALTH STATISTICS, HEALTH, UNITED STATES, 1998 WITH SOCIOECONOMIC STATUS AND HEALTH CHARTBOOK (1998).

51. Williams & Collins, *US Socioeconomic and Racial Differences in Health*, *supra* note 47, at 366; see generally Jay S. Kaufman et al., *Socioeconomic Status and Health in Blacks and Whites: The Problem of Residual Confounding and the Resiliency of Race*, 8 EPIDEMIOLOGY 621 (1997).

52. Nan L. Maxwell, *The Effect on Black-White Wage Differences of Differences in the Quantity and Quality of Education*, 47 INDUS. & LAB. REL. REV. 249, 249, 255 (1994).

53. U.S. CENSUS BUREAU, *supra* note 45, at 140.

54. *Id.*

55. See Derek A. Neal & William R. Johnson, *The Role of Premarket Factors in Black-White Wage Differences*, 104 J. POL. ECON. 869 (1996).

56. Williams & Collins, *US Socioeconomic and Racial Differences in Health*, *supra* note 47, at 367 (citing Sharon M. Collins, *The Making of the Black Middle Class*, 30 SOC. PROBS. 369 (1983)); see also COUNCIL OF ECON. ADVISERS FOR THE PRESIDENT'S INITIATIVE ON RACE, CHANGING AMERICA: INDICATORS OF SOCIAL AND ECONOMIC WELL-BEING BY RACE AND HISPANIC ORIGIN 26 (1998) [hereinafter CHANGING AMERICA: INDICATORS OF SOCIAL AND

[T]he purchasing power of a given level of income [also] varies by race, with blacks paying higher prices than whites for a broad range of goods and services in society, including food and housing. African Americans also have higher rates of unemployment and underemployment than do whites. Moreover, employed blacks are more likely than their white peers to be exposed to occupational hazards and carcinogens, even after adjusting for job experience and education.⁵⁷

A dramatic example of the nonequivalence of SES indicators is the large racial difference in wealth at all income levels. Racial differences in the inheritance of wealth and intergenerational transfers of wealth have contributed to the large racial differences in wealth shown in Table 4.⁵⁸ The chart shows that the average white family has about seven times as much wealth as the average Black and Hispanic family. Instructively, these racial differences in wealth are evident at every level of income, with both Black and Hispanic households having markedly lower levels of wealth than white households. Among persons at the lowest quintile of income, white households have six to seven times as much wealth as their Black and Latino counterparts. In the highest income quintile, white households have fifty percent more wealth than Hispanic ones and three times as much wealth as African-American ones.

ECONOMIC WELL-BEING BY RACE AND HISPANIC ORIGIN]; see generally Sharon M. Collins, *Black Mobility in White Corporations: Up the Corporate Ladder But Out on a Limb*, 44 SOC. PROBS. 55 (1997).

57. Williams & Collins, *US Socioeconomic and Racial Differences in Health*, *supra* note 47, at 367 (citing James C. Robinson, *Racial Inequality and the Probability of Occupation-related Injury or Illness*, 62 MILBANK MEM'L FUND QUARTERLY: HEALTH AND SOCIETY 567, 587 (1984)) (citations omitted).

58. *Id.* at 365. See also MELVIN L. OLIVER & THOMAS M. SHAPIRO, *BLACK WEALTH/WHITE WEALTH: A NEW PERSPECTIVE ON RACIAL INEQUALITY* 155-56 (1997).

Table 4⁵⁹

Median Net Worth by Race and Household Income, 1995

Household Income	White	Black	Hispanic
Total	\$49,030	\$7,073	\$7,255
Lowest Quintile	\$9,720	\$1,500	\$1,250
2 nd Quintile	\$26,534	\$3,998	\$3,898
3 rd Quintile	\$42,123	\$11,623	\$10,377
4 th Quintile	\$57,445	\$27,275	\$19,424
Top Quintile	\$123,781	\$40,866	\$80,416

A second reason for the persistence of racial differences in health after SES is accounted for is the potential contribution of early life exposure to adversity. In the larger literature on social factors and health, there is growing evidence that the health of adults is affected not only by current social conditions but also by exposure to social and economic adversity over the life course.⁶⁰ Thus, exposure to childhood social and economic adversity may contribute to health status disparities later in life.

Third, limited but growing scientific evidence suggests that experiences of discrimination constitute one type of stressful life experience that may adversely affect the health of socially disadvantaged groups. This rapidly growing literature indicates that experiences of racial discrimination are

59. MICHAEL E. DAVERN & PATRICIA J. FISHER, U.S. CENSUS BUREAU, CURRENT POPULATION REPORTS, HOUSEHOLD ECONOMIC STUDIES: HOUSEHOLD NET WORTH AND ASSET OWNERSHIP: 1995, at xiv (2001).

60. See, e.g., Williams & Collins, *US Socioeconomic and Racial Differences in Health*, *supra* note 47, at 375-76; HEALTH INEQUALITIES: LIFECOURSE APPROACHES (George Davey Smith ed., 2003).

adversely related to multiple indicators of physical and mental health.⁶¹ Moreover, some studies have documented that experiences of racial discrimination make an incremental contribution to the racial gap in health after indicators of SES are controlled.⁶²

Finally, racial differences in neighborhood living conditions and their consequences may make an important contribution to the racial gap in health in general and to racial differences in homicide and violent crime rates in particular.⁶³ Thus, the social and physical risks linked to neighborhood conditions may also adversely affect health and contribute to racial disparities in health on a larger scale in addition to the risk factors connected to individuals and households. Differential exposure to risks in the physical environment may also contribute to racial differences in health. The quality of housing is generally poorer in highly segregated areas, especially those inhabited by ethnic minorities.⁶⁴ Crowding, sub-standard housing, elevated noise levels, decreased ability to regulate temperature and humidity, as well as elevated exposure to noxious pollutants and allergens (including lead, smog, particulates, and dust mites) are all common in poor, segregated communities.⁶⁵ Research indicates that residing near hazardous waste sites,⁶⁶ residential exposure to air pollution,⁶⁷ and deteriorated housing conditions⁶⁸

61. See, e.g., Nancy Krieger, *Embodying Inequality: A Review of Concepts, Measures, and Methods for Studying Health Consequences of Discrimination*, 29 INT'L J. HEALTH SERVS. 295 (1999); David R. Williams et al., *Racial/Ethnic Discrimination and Health: Findings From Community Studies*, 93 AM. J. PUB. HEALTH 200 (2003).

62. See, e.g., David R. Williams et al., *Racial Differences in Physical and Mental Health: Socioeconomic Status, Stress, and Discrimination*, 2 J. HEALTH PSYCH. 335 (1997); Xinhua S. Ren et al., *Racial/Ethnic Disparities in Health: The Interplay Between Discrimination and Socioeconomic Status*, 9 ETHNICITY & DISEASE 151 (1999).

63. See generally David R. Williams & Chiquita Collins, *Racial Residential Segregation: A Fundamental Cause of Racial Disparities in Health*, 116 PUB. HEALTH REP. 404 (2001); see also Robert J. Sampson, *Urban Black Violence: The Effect of Male Joblessness and Family Disruption*, 93 AM. J. SOC. 348 (1987) (discussing the cultural effects of urban violence on the dynamic of family life and overall standard of living).

64. See Williams & Collins, *Racial Residential Segregation*, *supra* note 63.

65. Gary W. Evans & Susan Saegert, *Residential Crowding in the Context of Inner City Poverty*, in THEORETICAL PERSPECTIVES IN ENVIRONMENT-BEHAVIOR RESEARCH: UNDERLYING ASSUMPTIONS, RESEARCH PROBLEMS, AND METHODOLOGIES 247-48 (Seymour Wapner et al. eds., 2000); see generally Susan A. Perlin et al., *Residential Proximity to Industrial Sources of Air Pollution: Interrelationships Among Race, Poverty, and Age*, 51 J. AIR & WASTE MGMT. ASS'N 406 (2001).

66. See generally Helen Dolk et al., *Risk of Congenital Anomalies Near Hazardous-Waste Landfill Sites in Europe: The EUROHAZCON Study*, 352 LANCET 423 (1998); Mark S. Goldberg et al., *Risks of Developing Cancer Relative to Living near a Municipal Solid Waste Landfill Site in Montreal, Quebec, Canada*, 54 ARCHIVES ENVTL. HEALTH 291 (1999).

67. See, e.g., Gerald J. Keeler et al., *Assessment of Personal and Community-Level Exposures to Particulate Matter among Children with Asthma in Detroit, Michigan, as Part of Community Action Against Asthma (CAAA)*, ENVTL. HEALTH PERSP., Supp. 2, April 2002, at 173;

are related to increased respiratory and other health problems in both adults and children. Thus, differential exposure to risk in the social and physical environment because of SES may also contribute to racial differences in health.

Research on homicide provides an illustration of the differences that can result. One of the largest discrepancies in the health of ethnic populations is reflected in the black-white difference in homicide. The homicide death rate for African-Americans is markedly higher than that of whites and persists at every level of SES.⁶⁹ Moreover, the overall homicide rate of African-Americans has remained stable at a high level for a long time. For example, the age-adjusted Black homicide death rate was 30.5 per 100,000 in 1950 and 30.6 in 1996.⁷⁰ Sampson shows that the lack of educational and employment opportunity in poor, predominantly Black areas produces high rates of male unemployment and underemployment.⁷¹ These, in turn, lead to out-of-wedlock births, female-headed households and the extreme concentration of poverty.⁷² Sampson explains that single-parent households provide youth lower levels of social control and guardianship than two-parent households.⁷³ Sampson found a strong association between family structure and violent crime, with the magnitude of the relationship being virtually identical for whites and Blacks.⁷⁴ Thus, racial differences at the neighborhood level concerning the availability of jobs, family structure, opportunities for marriage, and concentrated poverty undergird racial differences in crime and homicide and contribute to overall health disparities. These racial differences are not trivial. In the nation's 171 largest metropolises, the worst urban context in which whites reside is markedly better than the average context of Black neighborhoods.⁷⁵

C. Arden Pope III et al., *Lung Cancer, Cardiopulmonary Mortality, and Long-term Exposure to Fine Particulate Air Pollution*, 287 JAMA 1132 (2002).

68. See, e.g., Jennifer K. Peat et al., *Effects of Damp and Mould in the Home on Respiratory Health: A Review of the Literature*, 53 EUR. J. ALLERGY & CLINICAL IMMUNOLOGY 120 (1998); Virginia A. Rauh et al., *Deteriorated Housing Contributes to High Cockroach Allergen Levels in Inner-City Households*, ENVTL. HEALTH PERSP., Supp. 2, April 2002, at 323.

69. See generally NAT'L CTR. FOR HEALTH STATISTICS, *supra* note 3.

70. NAT'L CTR. FOR HEALTH STATISTICS, U.S. DEP'T OF HEALTH & HUMAN SERVS., HEALTH, UNITED STATES, 2000 WITH ADOLESCENT HEALTH CHARTBOOK 164 (2000) (Table 30).

71. See Sampson, *supra* note 63, at 351.

72. *Id.* at 348.

73. *Id.* at 352-53.

74. *Id. passim.*

75. Robert J. Sampson & William J. Wilson, *Toward a Theory of Race, Crime, and Urban Inequality*, in CRIME AND INEQUALITY 42 (John Hagan & Ruth D. Peterson eds., 1995).

V. RACIAL AND ETHNIC DIFFERENCES IN ACCESS AND QUALITY OF MEDICAL CARE

In the face of striking data on racial inequalities in health, many individuals look to improved medical care as the solution; however, interventions in health care alone are unlikely to either eliminate social inequalities in health status or create optimal levels of population health.⁷⁶ A report released by the United States Surgeon General in 1979 indicated that medical care explained only approximately ten percent of the variation in adult mortality.⁷⁷ This observation has led to the widely held view that medical care makes a limited contribution to population differences in health status.⁷⁸ Medical care likely has a greater impact on the health status of vulnerable populations, such as racial and ethnic minorities and low SES groups, rather than on the population in general.⁷⁹ Healthcare may be an especially important health-protective resource for people or groups with multiple vulnerabilities, and the impact of medical care may also vary by the characteristics of that care. Considerable evidence indicates that greater access to more continuous preventive care and timely as well as appropriate secondary and tertiary care from concerned providers can reduce disparities in care and lead to improvements in health status.⁸⁰ Access to medical care and the receipt of high quality medical care, however, remain a significant challenge for many minority group members.

Many racial and ethnic minority populations face challenges in accessing medical care in the United States. Compared to whites, African-Americans, Latinos and some Asian populations have lower levels of insurance coverage, with Hispanics having greater barriers to health insurance than all other groups

76. See George A. Kaplan et al., *The Contribution of Social and Behavioral Research to an Understanding of the Distribution of Disease: A Multilevel Approach*, in PROMOTING HEALTH: INTERVENTION STRATEGIES FROM SOCIAL AND BEHAVIORAL RESEARCH 37 (Brian D. Smedley & S. Leonard Syme eds., 2000); James S. House & David R. Williams, *Understanding and Reducing Socioeconomic and Racial/Ethnic Disparities in Health*, in PROMOTING HEALTH: INTERVENTION STRATEGIES FROM SOCIAL AND BEHAVIORAL RESEARCH 81 (Brian D. Smedley & S. Leonard Syme eds., 2000).

77. PUBLIC HEALTH SERV., U.S. DEP'T OF HEALTH, EDUC. AND WELFARE, PUB. NO. 79-55071, HEALTHY PEOPLE: THE SURGEON GENERAL'S REPORT ON HEALTH PROMOTION AND DISEASE PREVENTION, at I-9 (1979).

78. Adler et al., *supra* note 46, at 3141-42.

79. David R. Williams, *Socioeconomic Differentials in Health: A Review and Redirection*, 53 SOC. PSYCHOL. Q. 81, 82-87 (1990).

80. House & Williams, *supra* note 76, at 108; Robert M. Politzer et al., *Inequality in America: The Contribution of Health Centers in Reducing and Eliminating Disparities in Access to Care*, 58 MED. CARE RES. & REV. 234, 235 (2001); Barbara Starfield, PRIMARY CARE: BALANCING HEALTH NEEDS, SERVICES, AND TECHNOLOGY 8 (1998).

in the United States.⁸¹ Table 5 presents the racial and ethnic variation in health insurance coverage among the non-elderly adult population.⁸² There is considerable heterogeneity within the Hispanic and Asian-American groups. For instance, uninsured rates are much higher for Mexicans and Central-Americans than for Puerto Ricans. Among Asian-Americans, Chinese, Japanese, Filipino, and Indian individuals, uninsured rates are comparable or lower than those of whites, while Koreans and Vietnamese have even lower levels of insurance coverage than Blacks.

Table 5⁸³

Health Insurance Coverage for U.S. Adults Aged 18–64, 2001

Population	Percent	
	Uninsured Now	Uninsured Past Year
1. Total U.S.	16	24
2. White	12	20
3. Black	22	30
4. Hispanic	35	46
4a. Mexican	39	49
4b. Central-American	47	55
4c. Puerto Rican	16	35
5. Asian-American	14	21
5a. Chinese	12	16
5b. Korean	52	55
5c. Vietnamese	32	37
5d. Filipino	6	15
5e. Indian	13	18
5f. Japanese	1	4

81. COMM. ON UNDERSTANDING AND ELIMINATING RACIAL AND ETHNIC DISPARITIES IN HEALTH CARE, INSTITUTE OF MEDICINE, *UNEQUAL TREATMENT: CONFRONTING RACIAL AND ETHNIC DISPARITIES IN HEALTHCARE* 83-87 (Brian D. Smedley et al. eds., 2003) [hereinafter *UNEQUAL TREATMENT*].

82. KAREN SCOTT COLLINS ET AL., *DIVERSE COMMUNITIES, COMMON CONCERNS: ASSESSING HEALTH CARE QUALITY FOR MINORITY AMERICANS* 57 (2002).

83. KAREN SCOTT COLLINS ET AL., *QUALITY OF CARE FOR AFRICAN AMERICANS: FINDINGS FROM THE COMMONWEALTH FUND 2001 HEALTH CARE QUALITY SURVEY* (2002); DORA L. HUGHES, *QUALITY OF CARE FOR ASIAN AMERICANS: FINDINGS FROM THE COMMONWEALTH FUND 2001 HEALTH CARE QUALITY SURVEY* (2002); MICHELLE M. DOTY & BRETT L. IVES, *QUALITY OF CARE FOR HISPANIC POPULATIONS: FINDINGS FROM THE COMMONWEALTH FUND 2001 HEALTH CARE QUALITY SURVEY* (2002).

Blacks and Hispanics are less likely than whites to have direct private employer-based insurance coverage or to have insurance coverage indirectly through a spouse's employment, but they are more likely than whites to have public insurance coverage.⁸⁴ These groups are also more likely than whites to receive care in non-optimal organizational settings (such as the emergency room) and to lack continuity in the health care received.⁸⁵ Thus, although many minorities have a greater need for medical care because of higher levels of morbidity, they are more likely than whites to face multiple barriers in accessing health care services. Analyses of racial and ethnic differences in access to and the use of health services between 1977 and 1996 has revealed that the Black/white gap has not narrowed over time, and the gap between Hispanics and whites has widened.⁸⁶ Moreover, this study found that even if income and health insurance coverage were equalized, racial and ethnic differences in having a usual source of care and in receiving ambulatory care in the past year would not be eliminated because one-half to three-quarters of the disparities on these indicators are not accounted for by such factors.⁸⁷

In addition to racial and ethnic differences in access to care, there is also considerable evidence documenting systematic racial and ethnic differences in the receipt of a broad spectrum of therapeutic interventions.⁸⁸ A recent Institute of Medicine (IOM) report, titled *Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare*, documents the large racial and ethnic differences in the quality and intensity of medical care in the United States.⁸⁹ For a diverse range of therapeutic procedures, varying from high-technology interventions to basic diagnostic and treatment measures, Blacks and other minorities are less likely to receive these medical procedures and more likely to experience poor quality medical care than whites.⁹⁰ This pattern of differences is robust even in studies that adjust for differences in health insurance, SES, stage and severity of disease, comorbidity, and the type of medical facility.⁹¹

84. See Robert J. Blendon et al., *Access to Medical Care for Black and White Americans*, 261 JAMA 278, 280 (1989); Martha A. Hargraves, *Uninsurance and Its Impact on Access to Health Care: What Are the Challenges for Policy?*, in MINORITY HEALTH IN AMERICA, *supra* note 22, at 142.

85. Blendon et al., *supra* note 84, at 280.

86. Robin M. Weinick et al., *Racial and Ethnic Differences in Access to and Use of Health Care Services 1977 to 1996*, 57 MED. CARE RES. & REV. 36, 42 (Supp. 1, 2000).

87. *Id.* at 49.

88. See, e.g., Robert M. Mayberry et al., *Racial and Ethnic Differences in Access to Medical Care*, 57 MED. CARE RES. & REV. 108, 112 (Supp. 1, 2000).

89. UNEQUAL TREATMENT, *supra* note 81, at 39.

90. *Id.* at 38-74.

91. See *id.* at 42.

Strikingly, racial and ethnic disparities in care persist in contexts where differences in insurance factors are minimized. Research reveals that there are systematic racial differences in the kind and quality of medical care received among Medicare beneficiaries.⁹² In an analysis of racial differences in the rates of procedures performed by hospitals for Medicare beneficiaries in 1992, McBean and Gornick found that Black Medicare beneficiaries were less likely than their white counterparts to receive seventeen of the most commonly performed procedures.⁹³ The differences appeared to be largest for referral-sensitive procedures.⁹⁴ Further examination of the Medicare files revealed that Black beneficiaries of Medicare received only four non-elective procedures more frequently than their white counterparts.⁹⁵ All of these procedures, such as the amputation of a lower limb and the removal of both testes, reflected delayed diagnosis and/or initial treatment or failure in the management of chronic disease.⁹⁶ Additionally, a greater percentage of Black Medicare beneficiaries make out-of-pocket payments for deductibles and copayments for ambulatory care than do whites.⁹⁷ This higher financial cost could lead to lower utilization of ambulatory medical care and the postponement and avoidance of treatment.⁹⁸

Similarly, in the Veterans Health Administration (VHA) system, where differences in insurance coverage are also minimized, racial disparities have been documented in the treatment of heart disease,⁹⁹ gallbladder disease¹⁰⁰ and

92. José J. Escarce et al., *Racial Differences in the Elderly's Use of Medical Procedures and Diagnostic Tests*, 83 AM. J. PUB. HEALTH 948, 949-51 (1993); A. Marshall McBean & Marian Gornick, *Differences by Race in the Rates of Procedures Performed in Hospitals for Medicare Beneficiaries*, HEALTH CARE FINANCING REV., Summer 1994, at 77, 80-85 (1994).

93. McBean & Gornick, *supra* note 92, at 85.

94. *Id.* at 77.

95. *Id.* at 84.

96. *Id.* at 84-85.

97. *Id.* at 85-86.

98. McBean & Gornick, *supra* note 92, at 85.

99. E.g., Eugene Z. Oddone et al., *Race, Presenting Signs and Symptoms, Use of Carotid Artery Imaging, and Appropriateness of Carotid Endarterectomy*, 30 STROKE 1350, 1352-54 (1999); Eric D. Peterson et al., *Racial Variation in Cardiac Procedure Use and Survival Following Acute Myocardial Infarction in the Department of Veterans Affairs*, 271 JAMA 1175, 1176-78 (1994); Steven P. Sedlis et al., *Racial Differences in Performance of Invasive Cardiac Procedures in a Department of Veterans Affairs Medical Center*, 50 J. CLINICAL EPIDEMIOLOGY 899, 900 (1997); Jeff Whittle et al., *Racial Differences in the Use of Invasive Cardiovascular Procedures in the Department of Veterans Affairs Medical System*, 329 NEW ENG. J. MED. 621, 622-23 (1993).

100. See generally Ahsan M. Arozullah et al., *Racial Variation in the Use of Laparoscopic Cholecystectomy in the Department of Veterans Affairs Medical System*, 188 J. AM. C. SURGEONS 604 (1999).

mental health.¹⁰¹ At the same time, no racial differences were found in the VHA system for the treatment of colorectal cancer.¹⁰² In addition, no racial differences were found in the treatment of prostate cancer in the Department of Defense medical facilities¹⁰³ or in the treatment of cervical cancer in the military health system.¹⁰⁴ A study of the treatment of acute myocardial infarction in the military health system found no racial differences in catheterization and revascularization procedures, but whites were more likely than non-whites to be considered for future catheterization.¹⁰⁵ At the present time, we do not know the extent to which the financial, structural, and institutional aspects of healthcare systems can facilitate or minimize variations in racial and ethnic disparities in care.

There are large geographic variations in care in the United States. These patterns may contribute to the racial and ethnic differences in health care quality; however, such considerations do not account for all of the observed differences in quality. Several studies have found racial and ethnic disparities in care in a single facility,¹⁰⁶ a single geographic location¹⁰⁷ and, in the case of cardiovascular disease, even after a broad range of hospital characteristics are considered.¹⁰⁸ However, this and other research suggests that geographic location does matter. For example, one study of inadequate pain management found that all patients treated in settings in which the patient population was primarily Black or Hispanic were more likely to receive inadequate analgesia than those treated in settings where the patient population was primarily

101. See generally Helen C. Kales et al., *Race, Psychiatric Diagnosis, and Mental Health Care Utilization in Older Patients*, 8 AM. J. GERIATRIC PSYCHIATRY 301 (2000).

102. Jason A. Dominitz et al., *Race, Treatment, and Survival among Colorectal Carcinoma Patients in an Equal-Access Medical System*, 82 CANCER 2312, 2316-17 (1998).

103. Scott A. Optenberg et al., *Race, Treatment, and Long-term Survival from Prostate Cancer in an Equal-Access Medical Care Delivery System*, 274 JAMA 1599, 1601-02 (1995).

104. John H. Farley et al., *Equal Care Ensures Equal Survival for African-American Women with Cervical Carcinoma*, 91 CANCER 869, 871 (2001).

105. Allen J. Taylor et al., *Can Characteristics of a Health Care System Mitigate Ethnic Bias in Access to Cardiovascular Procedures? Experience from the Military Health Services System*, 30 J. AM. C. CARDIOLOGY 901, 903-05 (1997).

106. E.g., Henry Chung et al., *Racial Differences in Treatment of Psychiatric Inpatients*, 46 PSYCHIATRIC SERVS. 586, 588 (1995); Richard D. Moore et al., *Racial Differences in the Use of Drug Therapy for HIV Disease in an Urban Community*, 330 NEW ENG. J. MED. 763, 764 (1994); Knox H. Todd et al., *Ethnicity as a Risk Factor for Inadequate Emergency Department Analgesia*, 269 JAMA 1537, 1538 (1993).

107. David J. Ramsey et al., *Sex and Ethnic Differences in Use of Myocardial Revascularization Procedures in Mexican Americans and Non-Hispanic Whites: The Corpus Christi Heart Project*, 50 J. CLINICAL EPIDEMIOLOGY 603, 607-08 (1997); Steven P. Segal et al., *Race, Quality of Care, and Antipsychotic Prescribing Practices in Psychiatric Emergency Services*, 47 PSYCHIATRIC SERVS. 282, 284-85 (1996).

108. UNEQUAL TREATMENT, *supra* note 81, at 43-48.

white.¹⁰⁹ Nonetheless, this study found that minority patients were more likely than white patients to be undermedicated for pain and more likely to have the severity of their pain underestimated by physicians.¹¹⁰

Geographic disparities may reflect both the particular institutions where minorities access care and the type and quality of their healthcare providers. Prior research indicates that regardless of insurance coverage, African-Americans and Hispanics are “almost twice as likely as whites to receive care from a hospital-based provider.”¹¹¹ Moreover, Blacks and Latinos are almost 1.6 times more likely than whites to be treated at safety net urban hospitals.¹¹² Some evidence also suggests that non-white patients are more likely than their white counterparts to be treated by lower quality physicians.¹¹³

It is generally recognized that multiple factors contribute to the observed disparities in health care.¹¹⁴ There are numerous explanations offered for racial and ethnic disparities in medical care including: the geographic maldistribution of health resources, policies and procedures of larger health systems, provider behavior towards patients, racial differences in patient preferences, human physiology, SES, insurance coverage, place of treatment and finally trust, knowledge and prior experience with medical procedures.¹¹⁵ The recent IOM report, however, concluded that discrimination on the part of providers based on the patient’s race and ethnicity contributes to racial and ethnic disparities in care.¹¹⁶ The IOM report also indicates that it is likely that this bias is unconscious or unthinking discrimination based on negative stereotypes.¹¹⁷ Research on stereotypes indicates that when an individual who holds a negative stereotype about a group meets someone who fits the stereotype, he or she will discriminate against that individual.¹¹⁸ Strikingly, stereotype-linked bias is both an automatic process and an unconscious one, even among persons who are not prejudiced!

Several lines of evidence suggest that discrimination based on negative stereotypes of minorities is likely to play a role in encounters between patients and providers in the United States. First, healthcare providers are a part of the

109. Charles S. Cleeland et al., *Pain and Treatment of Pain in Minority Patients with Cancer: The Eastern Cooperative Oncology Group Minority Outpatient Pain Study*, 127 ANNALS OF INTERNAL MED. 813, 814 (1997).

110. *Id.* at 815.

111. UNEQUAL TREATMENT, *supra* note 81, at 110.

112. *See generally id.*

113. *See* Dana B. Mukamel et al., *Racial Differences in Access to High-Quality Cardiac Surgeons*, 90 AM. J. PUB. HEALTH 1774, 1776 (2000).

114. *See* UNEQUAL TREATMENT, *supra* note 81.

115. *Id.*

116. *Id.* at 172 (indicating that “[n]egative stereotypes about minorities, held explicitly or implicitly by physicians, can contribute to healthcare disparities in a number of ways.”).

117. *Id.* at 172-73.

118. *Id.* at 173-74.

larger society that views racial and ethnic minorities negatively on multiple social dimensions. For example, national data reveal that whites view Blacks, Hispanics, and Asians more negatively than they view themselves, with perceptions of Blacks being the most unfavorable and Hispanics being viewed twice as negatively as Asians.¹¹⁹ Also, 44% of whites believe that Blacks are lazy, 51% believe that Blacks are prone to violence, and 56% believe that Blacks prefer to live on welfare.¹²⁰ Comparatively, whites view only 5% of whites as lazy, 16% as prone to violence, and 4% as preferring to live on welfare.¹²¹

Second, research on stereotypes indicates that encounters in the healthcare setting contain ingredients that enhance the likelihood of the use of stereotypes. Stereotypes are more likely to be activated under conditions of time pressure, the need to make quick judgments, cognitive overload, task complexity and when the emotions of anger or anxiety are present.¹²² The typical health care experience is often characterized by time pressure, brief encounters, and the need to manage complex cognitive tasks, providing a unique environment that supports stereotyping.

Third, the few studies that have examined how physicians perceive their patients indicate that Black patients are viewed more negatively than their white counterparts.¹²³ For example, van Ryn and Burke found that even after adjustment for patient age, sex, SES, sickness, frailty, overall health status, patient availability of social support and education level, physicians viewed Black patients (compared to their white counterparts) as less likely to adhere to medical advice, less likely to be kind, intelligent and educated, more likely to lack social support, and more likely to abuse alcohol and drugs.¹²⁴ Moreover,

119. See generally Davis et al., *supra* note 24; see also Lawrence D. Bobo, *Racial Attitudes and Relations at the Close of the Twentieth Century*, in 1 AMERICA BECOMING, *supra* note 23, at 264, 273-80.

120. Williams, *Racial Variations in Adult Health Status: Patterns, Paradoxes and Prospects*, in 2 AMERICA BECOMING, *supra* note 31, at 390. See generally Davis, *supra* note 24.

121. Williams, *Racial Variations in Adult Health Status: Patterns, Paradoxes and Prospects*, in 2 AMERICA BECOMING, *supra* note 31, at 390.

122. See Michelle van Ryn & Jane Burke, *The Effect of Patient Race and Socio-economic Status on Physicians' Perceptions of Patients*, 50 SOC. SCI. & MED. 813, 814 (2000). Also, the IOM report has concluded:

[W]hen individuals do not have the time, capacity, opportunity, or motivation to assess situations fully and deliberately, implicit attitudes automatically shape people's responses to objects, individuals, and groups. These conditions of time pressure, high cognitive demand, and stress are common to many healthcare settings, making these settings "ripe" for the activation of stereotypes.

UNEQUAL TREATMENT, *supra* note 81, at 173.

123. See van Ryn & Burke, *supra* note 122, at 814, 820; see also Thomas E. Finucane & Joseph A. Carrese, *Racial Bias in Presentation of Cases*, 5 J. GEN. INTERNAL MED. 120, 121 (1990).

124. van Ryn & Burke, *supra* note 122, at 820.

African-American patients were significantly less likely than whites to be perceived as the kind of person with whom the physician could see him or herself being friends.¹²⁵ In an experimental design, Abreu found that health professionals “primed” with negative stereotypes about African-Americans were more likely to view the same hypothetical patient negatively than therapists primed with neutral words.¹²⁶ Other experimental studies of physicians¹²⁷ and medical students¹²⁸ provide further evidence that the manipulation of demographic variables such as race can lead to variations in provider perceptions.

VI. CONCLUSION

This Article has documented the phenomenon that although there are large and persisting racial and ethnic inequalities in health status, access to health care, and the quality of health care, the majority of adults in the United States are unaware that these disparities exist. Knowledge of the extent of these disparities and their causes is a prerequisite for effective action. Intervention efforts can begin by ensuring every American full access to high quality medical care, but because racial and ethnic inequalities in health status reflect large inequalities in society, the other underlying determinants of health must also be tackled.

Analyses of economic and health data during the last fifty years reveal that the narrowing of the Black–white gap in economic status was associated with a parallel narrowing of the Black–white gap in health. Similarly, a widening of the racial gap in SES has been associated with a widening gap in health status.¹²⁹ Specifically, between the late–1960s and the mid–1970s, as a result of the gains of the Civil Rights Movement, there was some narrowing of the Black–white gap in income¹³⁰ and a corresponding narrowing of the racial gap

125. *Id.*

126. See José M. Abreu, *Conscious and Nonconscious African American Stereotypes: Impact on First Impression and Diagnostic Ratings by Therapists*, 3 J. CONSULTING & CLINICAL PSYCHOL. 387 (1999).

127. Kevin A. Schulman et al., *The Effect of Race and Sex on Physicians' Recommendations for Cardiac Catheterization*, 340 NEW ENG. J. MED. 618, 623 (1999); Carol S. Weisse et al., *Do Gender and Race Affect Decisions About Pain Management?*, 16 J. GEN. INTERNAL MED. 211, 215-16 (2001).

128. See Saif S. Rathore et al., *The Effects of Patient Sex and Race on Medical Students' Ratings of Quality of Life*, 108 AM. J. MED. 561, 563-64 (2000).

129. See David R. Williams, *Race and Health: Trends and Policy Implications*, in INCOME, SOCIOECONOMIC STATUS, AND HEALTH: EXPLORING THE RELATIONSHIPS 67-85 (James A. Auerbach & Barbara Kivimae Krimgold eds., 2001).

130. *Id.* at 71; see also CHANGING AMERICA: INDICATORS OF SOCIAL AND ECONOMIC WELL-BEING BY RACE AND HISPANIC ORIGIN, *supra* note 56.

in health status.¹³¹ Between 1968 and 1978, Black men and women experienced a larger decline in mortality across multiple causes of death, both on a percentage and an absolute basis, than their white counterparts.¹³² Life expectancy data during this period also showed larger gains for Blacks than whites on both a relative and an absolute basis.¹³³ During the early 1980s, on the other hand, the health status of economically vulnerable populations worsened in several states in the wake of substantial changes in social and economic policies at the national level.¹³⁴ Similarly, the Black–white gap in health status widened between 1980 and 1991 for multiple health outcomes, including life expectancy, excess deaths, and infant mortality.¹³⁵

Good health is a desirable resource. It is a prerequisite for the full realization of all of the fundamental rights and privileges that are central to the American dream. However, the evidence reviewed indicates that health is unevenly distributed by race and ethnicity across the population of the United States. Moreover, the cause of racial and ethnic disparities in health is not obscure or unknown. Instead, racial differences in health are driven by racial and ethnic inequalities across a broad range of societal sectors. There is a need for a major redefinition of health policy to include all societal policies that have health consequences. Equally important, there is a need for a new national commitment to eliminate inequalities by race and ethnicity that must be supported by a broad-based action agenda that involves the cooperation and coordination of multiple sectors of society and multiple departments of national, state, and local government. That is, eliminating racial and ethnic inequalities in health status will require a major new effort to address the fundamental non-medical determinants of health by improving the quality of a broad range of living conditions for vulnerable populations.¹³⁶

131. Richard Cooper et al., *Improved Mortality Among U.S. Blacks, 1968–1978: The Role of Antiracist Struggle*, 11 INT'L. J. HEALTH SERVS. 511, 519–20 (1981).

132. *See id.*

133. *Id.* at 515.

134. Nicole Lurie et al., *Termination from Medi-Cal—Does it Affect Health?*, 311 NEW ENG. J. MED. 480, 482–84 (1984); Mary O'Neil Munding, *Health Service Funding Cuts and the Declining Health of the Poor*, 313 NEW ENG. J. MED. 44, 44–47 (1985).

135. Williams & Collins, *US Socioeconomic and Racial Differences in Health*, *supra* note 47.

136. *See, e.g.*, INDEPENDENT INQUIRY INTO INEQUALITIES IN HEALTH REPORT (Sir Donald Acheson, Chairman, 1998), <http://www.archive.official-documents.co.uk/document/doh/ih/ih.htm>.

